7 AAC 43.672. APPLICABILITY. (a) All health facilities seeking payment from the Department of Health and Social Services for services provided to Medicaid and General Relief Medical recipients in the State of Alaska are subject to the provisions of 7 AAC 43.670 — 7 AAC 43.709.

(b) To receive a change in a prospective payment rate, a health facility must obtain the department's approval in accordance with the procedures set out in 7 AAC 43.670 — 7 AAC 43.709. (Eff. 10/21/84, Register 92; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.25.195

7 AAC 43.673. DUTIES OF THE DEPARTMENT. (a) The department will establish prospective payment rates in accordance with 7 AAC 43.701 for facilities not less than annually for each facility.

(b) The department will, in its discretion, establish temporary prospective payment rates for facilities pending full review of the annual budget submittal under 7 AAC 43.680. The temporary rate will be retroactively adjusted to conform to the final rate approved by the department. In no event will a temporary rate be approved if the facility has not complied with the reporting requirements of 7 AAC 43.679(b) and (c). (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.110 AS 47.07.180

7 AAC 43.674. OBJECTIVES. Repealed 8/9/86.

7 AAC 43.675. MEDICAID RATE ADVISORY COMMISSION OPERATIONS AND PROCEDURES. (a) Officers of the Medicaid Rate Advisory Commission are a chairperson and vice-chairperson. At the first commission meeting of each calendar year, the commission will elect a chairperson and a vice-chairperson from among its members.

(b) The chairperson will preside at all meetings. The vice-chairperson will preside in the absence of the chairperson. In the absence of both the chairperson and the vice-chairperson, a temporary presiding chairperson for the meeting will be appointed by the commission members present at the meeting.

(c) The administrative office of the commission will be open each day for the transaction of business from 8:00 a.m. to 4:30 p.m. except Saturdays, Sundays, and legal holidays. All official correspondence to the commission must be sent to the administrative office.

(d) Meetings of the commission will be held at least quarterly and at other times and locations as determined by the majority of the

commission members. The location of each meeting will be announced in an agenda that will be mailed to each person on the commission's general mailing list. A person will be placed on that list if a written request is filed with the commission.

(e) A vacancy on the commission does not impair the commission's power to act.

(f) The chairperson has the right to vote in all matters before the commission.

(g) Minutes will be kept of the proceedings and of actions taken by the commission.

(h) With the exception of the commission member listed in AS 47.07.120(2), a commission member may not vote on facility prospective payment rates if that member has a direct or indirect financial or fiduciary interest in an entity that provides health care services. (Eff. 8/9/86, Register 99; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.170 AS 47.07.180
AS 47.07.160

Editor's notes. — The location and mailing address of the administrative office of the commission are the same: 3601 "C" Street, Suite 592, P.O. Box 240249, Anchorage, Alaska 99524-0249.

7 AAC 43.676. PROSPECTIVE RATES DEFINED. (a) Prospective payment rates are the unit of payment to be paid by the division of medical assistance for services rendered by facilities for recipients of Medicaid and General Relief Medical programs.

(b) Prospective payment rates will be a percentage of charges for services rendered in acute care hospitals and specialty hospitals not including outpatient clinical laboratory services. The prospective payment rate will be a per-procedure rate for outpatient clinical laboratory service. Charges to the division of medical assistance may not exceed the usual and customary charges for the facility.

(c) Prospective payment rates will be a per-day rate for long-term care facilities and intermediate care facilities for the mentally retarded.

(d) Prospective payment rates will have an effective date. Services provided will be paid by the division of medical assistance at the rate in effect at the time the service was provided. For services provided that are to be paid under different prospective payment rates, the facility must provide the division of medical assistance with separate bills for each prospective payment rate period.

(e) Prospective payment rates will be a per-visit rate for rural health clinics.

(f) Prospective payment rates will be a per-procedure rate for outpatient surgical clinics. (Eff. 8/9/86, Register 99; am 5/8/88, Register 106; am 6/19/88, Register 106)

Authority: AS 49.07.070

7 AAC 43.678. MEDICAID RATE COMMISSION ORGANIZATION. Repealed 8/9/86.

7 AAC 43.679. ESTABLISHMENT OF UNIFORM ACCOUNTING, BUDGETING, AND FINANCIAL REPORTING. (a) The department adopts a uniform system of accounting, financial reporting, budgeting, cost allocation, and prospective rate setting for facilities. The system is described in the department's publication entitled "Medicaid Rate Commission Accounting and Reporting Manual" (manual), dated June 1987, which is incorporated by reference. Each facility shall use the manual for submitting information required by the department pertaining to prospective rates for payment of Medicaid and General Relief Medical assistance programs. Regarding the uniform system,

(1) Upon receipt of a request, in detail satisfactory to the department, the department will, in its discretion, approve an alternate reporting system for information required under 7 AAC 43.680.

(2) Repealed 8/6/92.

(3) The executive director of the Medicaid Rate Advisory Commission is authorized to make uniformly applicable interpretive rulings with respect to matters contained in the manual. The executive director of the commission is authorized to correct typographical and coding errors as well as make other minor organizational modifications when such corrections and modifications appear to be necessary.

(4) Any interpretive rulings, corrections, or modifications by the executive director must be in writing and distributed as an attachment of a consecutively numbered transmittal. The transmittal must describe the changes in detail, and must include instructions regarding the placement of the material in the manual. Each facility and manual holder of record must be sent a copy of any such transmittal together with all attachments.

(b) Each facility shall submit its budget and rate information to the commission not less than 60 days before the beginning of its fiscal year. The budget information and rate request must contain that information specified in the department's manual and must be submitted in the form and manner specified in the manual. If more than one facility is operated by the reporting organization, the informa-

tion required by this subsection must be reported for each facility separately. The chief executive officer and chairman of the governing board of the facility must attest that the information submitted under this subsection, including any subsequent modifications, has been examined by that person and to the best of that person's knowledge the information is correct.

(c) Each facility shall submit its year-end report to the commission staff within 120 days after the close of the facility's fiscal year, in a form and manner as specified in the manual, including the audited financial statements and the Medicare/Medicaid report. The department will, in its discretion, grant an extension of the due date of up to 60 days for the year-end report required in this subsection. If more than one facility is operated by the reporting organization, the information required by this subsection must be reported for each facility separately. The year-end report submitted under this subsection, including any subsequent modifications of it, must be certified by the facility's

(1) certified public accountant; or

(2) administrative and fiscal officers who, under oath, indicate that, to the best of their knowledge, all reports have been prepared in accordance with the prescribed system of accounting and reporting, and fairly state the financial position of the facility as of the specified date.

(d) Rural health clinics are exempt from the reporting requirements of (b) of this section.

(e) Outpatient surgical clinics are exempt from the reporting requirements of (b) of this section. (Eff. 8/9/86, Register 99; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/4/87, Register 102; am 7/20/88, Register 107; am 8/6/92, Register 123)

Authority: AS 47.07.073 AS 47.07.074

Editor's notes. — The Medicaid Rate Commission Accounting and Reporting Manual is available from the Medicaid Rate Commission, 4792-1 Business Park Boulevard, Building F, Anchorage, Alaska 99503.

7 AAC 43.680. PROCESSING OF ANNUAL BUDGET SUBMITTALS. (a) Commission staff shall process facilities' annual budget submittals. Each budget submittal must be date-stamped upon receipt in the commission office. The date of receipt in the commission office must be acknowledged by staff in written notice. The notice must also indicate the date that the staff expects the annual budget submittal to be considered by the commission in an informal hearing.

(b) Within 10 days after receipt of an annual budget submittal, commission staff shall review the submittal to determine whether it is complete and conforms to department's regulations, policies, and instructions, and whether the data is verifiable.

(c) Written notice must be provided by mail to the facility within the 10-day review period if the staff determines that the annual budget submittal is incomplete; fails to conform with department regulations, policies, or instructions; or contains data that cannot be verified. The notice must clearly indicate the deficiencies found, and the corrections or modifications that must be made in the submittal to make it complete or conforming, or to make its data verifiable. The time by which the corrected or modified submittal must be received in the commission office must also be noted. In no event may a facility be provided less than seven days following receipt of the notice to return to the commission's office the requested corrected or modified submittal. If a facility is not notified under this subsection, the annual budget submittal is considered complete and conforming, and as having verifiable data.

(d) If the data requested under (c) of this section is returned to the commission office within the specified period, commission staff shall make reasonable efforts to continue the processing of the submittal as if there had been no delay.

(e) If commission staff determines under (b) of this section that the annual budget submittal is complete and conforming, the staff shall commence processing and verifying the data contained in the submittal. If the staff determines that the data contained in the submittal is verifiable, the staff shall complete its processing of the submittal and prepare its findings and recommendations.

(f) Upon completion of the staff review of a facility's annual budget submittal, the staff shall prepare a written statement of findings and recommendations to the commission. The statement must include:

(1) an analysis of historical expenditures and rates that result from inflation adjustments;

(2) an analysis of changes in capital costs, including depreciation, interest, and leasing costs;

(3) an analysis of the program changes identified by the facility for the upcoming budget year;

(4) recommendations of staff regarding the rates to be paid by the division of medical assistance for Medicaid and General Relief Medical assistance programs;

(5) other matters that the staff considers important.

(g) A copy of the staff's statement must be mailed to the facility not less than 20 days before the date set for the commission consideration of the facility's annual budget submittal. Copies of the statement must also be mailed by that date to commission members and to the division of medical assistance.

(h) Not less than 20 days before the date set for commission consideration of a facility's annual budget submittal, the staff shall pro-

vide notice to the facility and those persons on the commission's general mailing list regarding the impending hearing.

(i) A facility may submit to the commission a response to the staff findings and recommendations. The response must be received in the commission office not less than three days before the date set for commission consideration of the facility's annual budget submittal in an informal hearing. Response received after that date might or might not, in the commission's discretion be considered by the commission.

(j) Rural health clinics are exempt from the requirements of (a), (b), (c), (d), (e), and (f) of this section.

(k) Outpatient surgical clinics are exempt from the reporting requirements of (a) — (f) of this section.

(*l*) If staff initiates any changes in staff recommendations in the report less than five working days before the informal proceeding, the facility has the option of continuing the proceeding to the next commission meeting. (Eff. 8/9/86, Register 99; am 7/20/88, Register 107; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.073 AS 47.07.180

7 AAC 43.681. PENALTIES. (a) If a facility fails to submit a year-end report as required in 7 AAC 43.679(c), or files an incomplete report, its rates will be automatically reduced by 20 percent until the report is received and certified by the staff to be complete. The staff shall notify the division of medical assistance on the 30th day after the reports are due whether the reports were received and certified by the staff to be complete.

(b) For each month or part of a month by which a facility fails to submit the information required in 7 AAC 43.679(b), or fails to file complete information, the rates for one month of its budget year will automatically be set at 80 percent of the current approved rates. (Eff. 7/4/87, Register 102)

Authority: AS 47.07.070 AS 47.07.110 AS 47.07.180

7 AAC 43.682. SUBMISSION OF BUDGET AMENDMENTS BY HEALTH FACILITIES. Repealed 8/9/86.

7 AAC 43.683. INFLATION FACTORS. (a) Semiannually the department will adopt inflation factors to be used in determining prospective payment rates for all facilities. The department will adopt inflation factors by September 1 for facilities with fiscal years beginning January through June, and by March 1 for facilities with fiscal years beginning July through December. The department will consider the following criteria in determining the inflation factors:

(1) national and regional inflation trends specific to health care;

(2) economic conditions within the state;

(3) regional differences within the state;

(4) budget inflationary factors in medical assistance appropriations set by the legislature; and

(5) other factors the department deems appropriate.

(b) The inflation factors will separately identify annual rates of inflation used to develop the inflation factor and will be consistently applied year to year. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 8/6/92, Register 123)

Authority: AS 47.07.070 AS 47.07.180

7 AAC 43.684. PROCESSING OF BUDGETS AND BUDGET AMENDMENTS. Repealed 8/9/86.

7 AAC 43.685. METHODOLOGY AND CRITERIA FOR APPROVAL OR MODIFICATION OF A FAIR RATE OF PAYMENT FOR MEDICAL ASSISTANCE PROGRAMS. (a) The following methodology and criteria will be used by the department in reviewing and setting prospective payment rates for medical assistance programs; the relative importance of each criterion is a matter of department discretion:

(1) whether the costs are reasonable given prudent and cost-effective management and operation of the facility;

(2) whether the costs are related to patient care and are attributable to the Medicaid and General Relief Medical assistance programs;

(3) whether the prospective rate is reasonably related to costs;

(4) whether the prospective rates are the most reasonable under the circumstances, considering the

(A) rate of use by medical assistance beneficiaries in acute care;

(B) rate of use by medical assistance beneficiaries in long-term care;

(C) overall acute care occupancy; and

(D) overall long-term care occupancy.

(b) For facilities and services of facilities whose respective methodologies for determining a fair rate of payment are not described in this section, the department will determine a fair rate of payment based on actual costs per occasion of service as allowed in 7 AAC 43.686 for the facility's fiscal year ending 12 months before the prospective fiscal year. The actual allowable operating costs will be calculated and adjusted as follows:

(1) The actual allowable operating costs per occasion of service will be calculated from the Medicare cost report for the applicable

fiscal year with adjustments as prescribed in the manual if the Medicare cost report does not allocate costs in the required manner.

(2) Actual operating costs less capital costs, which are interest on long-term debt, depreciation, amortization, leases and rentals for real property, exclusive of equipment, property taxes on real property used for direct patient care, and insurance on fixed assets, will be adjusted forward based on a compound rate of inflation as outlined in 7 AAC 43.683. For long-term care facilities and intermediate care facilities for the mentally retarded, the ancillaries will be separately identified from the daily facility expenses.

(3) Interest on long-term debt, depreciation, amortization, leases and rentals for real property, exclusive of equipment, and property taxes on real property used for direct patient care, will be considered based on budget data submitted by the facility as follows:

(A) For facilities that contain both long-term care services and acute care services, budgeted depreciation, interest, and amortization will be allocated using the same methodology as was allowable in the base year.

(B) Additional building depreciation and interest due to the construction of additional beds will be adjusted to reflect 50 percent of the base year occupancy.

(C) An appropriate allowance for depreciation, interest on capital indebtedness and capital for an asset of a hospital that has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with 42 U.S.C. 1395x(v)(1)(O)(i); in addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 U.S.C. 1395x(v)(1)(O)(ii); payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 U.S.C. 1395x(v)(1)(O)(iii); for long-term care facilities, capital assets used by the prior owner in the medical valuation of general relief medical programs for purposes of determining payment rates will not be increased, as measured from the date of acquisition by the seller to the date of the change of ownership, solely as a result of a change of ownership, by more than the lesser of

(i) one-half of the percentage increase, as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the secretary of the U.S. Department of Health and Human Services in the Dodge Construction Systems

Costs for Nursing Homes, applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year or,

(ii) one-half of the percentage increase, as measured over the same period of time, in the Consumer Price Index for All Urban Consumers (United States city average).

(D) For facilities that contain long-term care services, acute care services, or both, the department will determine as a capital cost

(i) the reasonable cost for arms-length transactions for leases and rentals for real property, exclusive of equipment, used for direct patient care, and

(ii) the actual cost for property taxes on real property used for direct patient care.

(4) The department will require the following revenue offsets for determining a fair rate for Medicaid and General Relief Medical assistance programs:

(A) other operating revenue as defined in 7 AAC 43.686(e);

(B) tax revenue designated by the taxing authority for payment of interest expense on bonds and operating costs;

(C) donations or grants that are donor-restricted for operating costs as allowed in 7 AAC 43.686.

(c) If a new facility is licensed, the rates for the first two years of operating will be calculated as follows:

(1) for acute care, the percentage of charges will be set at the statewide weighted average of percentage of charges for the most recent 12 months of actual data available in the commission office;

(2) for long-term care, the rate will be set at the swing bed rate currently in effect, less the average capital costs contained in the swing bed rate, plus the inflation factor adopted under 7 AAC 43.683, plus the capital costs identified by the new facility, assuming a first year occupancy rate of 40 percent and a second year occupancy rate of 60 percent on licensed beds.

(d) The department will determine the percentage of charges for acute care hospitals and specialty hospitals by calculating the ratio of allowable operating costs less the required revenue offset per adjusted admission in the base year, to actual revenue, not to exceed 100 percent of projected charges. The allowable increase or decrease will be calculated in accordance with (b) of this section.

(e) The department will determine a per diem rate for long-term care and intermediate care for the mentally retarded by totalling the allowable operating costs for the daily rate and the average ancillary cost per day, less the required revenue offsets. For a facility that's fiscal year begins on or after January 1, 1995, the department will determine a per diem rate for long-term care and intermediate care

for the mentally retarded by totalling the allowable operating costs for the daily rate and the average ancillary lower of costs or charges per day, less the required revenue offsets. The per diem rate may not exceed charges rendered to the general public. For purposes of this subsection, allowable operating costs are as determined in 7 AAC 43.686.

(f) In using the criteria in (a) of this section, the department will compare the allowable costs less capital costs calculated in (b) of this section plus the appropriate annual inflation identified in 7 AAC 43.683(5) (base year allowable costs) to the approved allowable operating costs less capital per occasion of service in the year preceding the budget year (approved allowable costs) and will apply the following:

(1) if the base year allowable costs exceed the approved allowable costs, the allowable costs will be limited to the approved allowable costs plus the appropriate inflation factor identified in 7 AAC 43.683(b) plus 50 percent of the difference between the allowable costs of the two years, limited to 5 percent of the costs in the base year;

(2) if the allowable costs are less than the approved allowable costs, rates will be calculated in accordance with (b) of this section plus 50 percent of the difference between the allowable costs of the two years, limited to 5 percent of the costs in the base year;

(3) for long-term care facilities, allowable costs do not include ancillary costs.

(g) For long-term care services provided on or after November 1, 1988, the department will limit the routine portion of the rate for a long-term care facility to one that is the lesser of either the rates for the long-term care facility as calculated in (a) — (f) of this section or the maximum cap, calculated under (1) — (3) of this subsection. The department will, under (1) — (3) of this subsection, recalculate the maximum cap every six months and will reset prospective rates for all long-term care facilities for the subsequent six-month period by applying the new maximum cap established for that period. The maximum cap is calculated as follows:

(1) The department will place all long-term care facilities whose rates are set under AS 47.07.070 into three categories, consisting of free-standing facilities, facilities co-located with hospitals, and state-owned facilities.

(2) The department will calculate a separate maximum cap for the long-term care facilities listed in each of the three categories listed in (1) of this subsection. The department will calculate the maximum cap for each category semi-annually, for the periods of January 1 — June 30 and July 1 — December 31.